

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LA PLATA (RURAL)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X LA PLATA (RURAL)	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BESSIE M. BAILEY		4. DATE OF DEATH Month 3 Day 5 Year 1962	
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 18, 1907
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEMUEL DODSON		14. MOTHER'S MAIDEN NAME CORA CHUN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MASCELIA GRAY, LA PLATA, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 3-5-62			
ACTUAL SIGNATURE E. J. EDELEN		DATE SIGNED 3-5-62	
EXAMINER'S NAME (Type) E. J. EDELEN		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-9-62	22c. NAME OF CEMETERY OR CREMATORY ZION BAPTIST	22d. LOCATION (City, town, or country) (State) Hilltop, MARYLAND
23. FUNERAL DIRECTOR HUNT FUNERAL HOME, WADSWORTH, MD.		24a. REC'D BY REGISTRAR MAR 12 '62	
24b. REGISTRAR'S SIGNATURE W. L. S. K...			

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any tests necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Fill 309 3-21-62

Item 14 Film G309 3/20/62 JWK

Item 14 Film G309 3/20/62 JWK

03116

03106

1. PLACE OF DEATH
a. COUNTY Charles MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FUGHESSVILLE 104
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Va b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA
d. STREET ADDRESS Temple Trailer Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) STERLING FURMAN ERVIN
First Middle Last
4. DATE OF DEATH 3 11 1962
Month Day Year

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-10-15
WIDOWED ☐ DIVORCED ☐ 47 yrs.
9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) W. VA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BENJAMIN ERVIN
14. MOTHER'S MAIDEN NAME Artie Wymer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 343-01-9859
16. SOCIAL SECURITY NO. MARY ANN ERVIN
17. INFORMANT ALEXANDRIA VA.
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
825X DUE TO FRAC SKULL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO AUTO ACCIDENT (DRIVER ALONE)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. DRIVER OF AUTO WHICH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 7:30 3/11 19 62
Hour a.m. Xpoc
20d. INJURY OCCURRED White Not White
at work ☐ at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hwy
20f. (City or town) (County) (State) Hughesville Chas. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE E J EDELEN M.D. ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) E J EDELEN DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) 3-11-62

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 3/14/62
22c. NAME OF CEMETERY OR CREMATORY 104 HILL CEMETERY
22d. LOCATION (City, town, or country) (State) ALEXANDRIA, VA.

23. FUNERAL DIRECTOR EVERLY-WHEATLEY FUNERAL HOME
ADDRESS ALEXANDRIA, VA
24a. REC'D BY REGISTRAR DATE MAR 13 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Thane



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>12678</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>03117</div> </div> <div> <div>04168</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div>													
1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gallant Green c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gallant Green d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle Last FORD			4. DATE OF DEATH Month 3 Day 11 Year 1962			5. SEX Male			6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 55 ? yrs.			9. AGE (In years last birthday) 55 ? yrs.			IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Stab wound of chest with penetration of lung (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) dressed on wood pile. Throat slashed, compound fracture skull, stab wound of abdomen & chest and lacerations of scalp and hands										
20c. TIME OF INJURY Hour 4 a.m. 3-11 p.m. 19 62			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) Gallant Green (County) Charles (State) Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input type="checkbox"/>. Inquiry <input type="checkbox"/>. and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			RUSSELL S. FISHER, M.D.						CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3-13-62	
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Maryland			22d. LOCATION (City, town, or country) (State)				
23. FUNERAL DIRECTOR ADDRESS						24a. REC'D BY REGISTRAR MAY 4 '62			24b. REGISTRAR'S SIGNATURE Arthur S. Kenna				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03118

CERTIFICATE OF DEATH

03107
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Franklin</u> Last <u>Franklin</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNE 1879</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Franklin</u>		14. MOTHER'S MAIDEN NAME <u>Not known.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary E. Linkins</u>		Address <u>Rison, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1961</u> to <u>March 19, 1962</u> that I last saw the deceased alive on <u>March 19, 1962</u> and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D. <u>Rt 1 Box 50</u>		DATE SIGNED <u>3/19/62</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		<u>Indian Head, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-21-62</u>	<u>OAK GROVE CEM.</u>	<u>NANJEMOY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 23 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>10/15/1925</u></p>	
<p>5. Place of birth: <u>New York City, N.Y.</u></p>		<p>6. Date of death: <u>11/10/1970</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>11/15/1970</u></p>		<p>12. Registrar's name: <u>John Smith</u></p>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03119

03108

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIRANDA Middle E. Last GARNER		4. DATE OF DEATH Month MARCH Day 26 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1882
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LEMUEL WILLIAMS		14. MOTHER'S MAIDEN NAME ELIZABETH ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HOWARD GARNER, WALDORF, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-42X DUE TO anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Denovelye Carlos Vascular Rndel Alburno Insom DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-5 1954 to 3-26 1962 that (I) (we) last saw the deceased alive on 3-26 1962 and that death occurred at 5:45 A M, from the causes and on the date stated above.			
22a. SIGNATURE Richard H. Dobson		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICHARD H. DOBSON M.D.		22d. ADDRESS Brandywine, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-28-62	
23c. NAME OF CEMETERY OR CREMATORY OAKLAND		23d. LOCATION (City, town, or county) (State) WALDORF MD.	
24. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, MD.		25a. REC'D BY REGISTRAR DATE MAR 30 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03120

03109

1 PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) PHYSICIANS MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Guy Last Gray		4. DATE OF DEATH Month March Day 20 Year 1962	
5 SEX Male	6 COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 16 Aug 1898
9 AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY GRAY		14 MOTHER'S MAIDEN NAME SALLY WALLACE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-38-3371	
17 INFORMANT MASCELIA GRAY, LA PLATA, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral vascular accident DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min 5 days 4 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes + Syphilis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 2 Nov 1962 to 20 March 1962 that (I) (we) lost the deceased alive on 20 March 1962 and that death occurred 10:30 M, from the causes and on the date stated above			
22a SIGNATURE Dr. Wooddy		22b DATE 21 March 1962	
22c PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY, MD		22d ADDRESS LA PLATA, MARYLAND	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3-23-62	
23c NAME OF CEMETERY OR CREMATORY MT REST		23d LOCATION (City, town, or county) (State) LA PLATA, MARYLAND	
24 FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		25a REC'D BY REGISTRAR 27 '62	
25b. REGISTRAR'S SIGNATURE S. Rouse			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03110

1. PLACE OF DEATH

a. COUNTY

Charles

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Indian Head

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Old Indian Head Road

3. NAME OF DECEASED

(Type or print)

THOMAS

William

Middle

Last

4. DATE OF DEATH

Month

Day

Year

3

10

1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

☒

8. DATE OF BIRTH

12-9-43

9. AGE (In years last birthday)

18

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas H. Headley

14. MOTHER'S MAIDEN NAME

Edna Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address Indian Head ...

Mr. Thomas Headley - 55 Elder Place

18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

3-10-62

3-10-62

3-10-62

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Driver of automobile hit a tree.

20c. TIME OF INJURY

Month, Day, Year

7:23 a.m.

3-10-62

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Highway

20f. (City or town)

Lees Ferry, Charles County, Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☐ inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

E. J. EDELEN

M. D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

3-10-62

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

3/12/62

22c. NAME OF CEMETERY OR CREMATORY

Trinity Memorial Gardens

22d. LOCATION (City, town, or country)

Indian Head, Maryland

22e. (State)

Maryland

23. FUNERAL DIRECTOR

Lebanon Funeral Home, Inc.

24a. REC'D BY REGISTRAR

DATE MAR 14 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. House

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VI. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03111

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5 YRS.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOUGLAS H. JONES</u>		4. DATE OF DEATH Month Day Year <u>MARCH 1, 1962</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 6, 1956</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD LAWRENCE JONES</u>		14. MOTHER'S MAIDEN NAME <u>ELEANOR SWANN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>ELEANOR JONES, WALDORF, MD.</u>	
17. INFORMANT <u>ELEANOR JONES, WALDORF, MD.</u>		18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLAGRATION</u> 716.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>INTERVAL BETWEEN ONSET AND DEATH 3-1-62</u> (a), stating the underlying cause last. DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Home burned</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>10:30</u> p.m. <u>Mar 1</u> 19 <u>62</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Waldorf Char</u>		20g. (County) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		M.D. DATE SIGNED <u>3-1-62</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		Address (Street, city, town, or county) <u>LA PLATA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-7-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HUNTT FUNERAL HOME, WALDORF, MD.</u>		22d. LOCATION (City, town, or country) (State) <u>PITTSBURG, KANSAS</u>	
23. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME, WALDORF, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

1 FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03112

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF (RURAL)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD LAWRENCE JONES		4. DATE OF DEATH Month Day Year MARCH 1, 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1914
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEMIST		10b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT.	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E. W. JONES		14. MOTHER'S MAIDEN NAME HALLIE JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 479-03-1589	
17. INFORMANT ELEANOR JONES WALDORF, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO CONFLAGRATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3-1-62			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home burned	
20c. TIME OF INJURY Month, Day, Year Hour am. 10:30 p.m. MAR 1 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) WALDORF Chas Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-7-62	
22c. NAME OF CEMETERY OR CREMATORY HUNTT FUNERAL HOME, WALDORF, MD.		22d. LOCATION (City, town, or country) (State) PITTSBURG, KANSAS	
23. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.		24a. REC'D BY REGISTRAR DATE MAR 6 '62	
24b. REGISTRAR'S SIGNATURE C. L. H. S. HUNTT		DATE SIGNED 3-1-62	

MEDICAL CERTIFICATION

08

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03113

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>WALDORF</u> <u>RURAL</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u>			
c. LENGTH OF STAY IN b. <u>12 YRS.</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN BRUCE JONES</u>				4. DATE OF DEATH <u>MARCH 1, 1962</u>			
5. SEX <u>MALE</u>				6. COLOR OR RACE <u>WHITE</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>MAY 8, 1949</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>EDWARD LAWRENCE JONES</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR SWANN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>ELEANOR JONES WALDORF, MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>916.0</u> DUE TO <u>CONFLAGRATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>INTERVAL BETWEEN ONSET AND DEATH 3-1-62</u> (c) <u>3-1-62</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Home burned</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. Mar 1 1962</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Waldorf Ches</u> (County) <u>MD</u> (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE <u>E. J. EDELEN</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. NAME OF CEMETERY OR CREMATORY				22b. LOCATION (City, town, or country) (State)			
22c. DATE THEREOF <u>3-7-62</u>				22d. LOCATION (City, town, or country) (State) <u>PITTSBURG, KANSAS</u>			
23. FUNERAL DIRECTOR <u>HUNT Funeral Home, WALDORF, MD.</u>				24a. REC'D BY REGISTRAR <u>MAR 6 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03114

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u> c. LENGTH OF STAY IN b. <u>10 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WALDORF (RURAL)</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARK RANDALL JONES</u> First Middle Last 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MAY 13, 1961</u> 9. AGE (In years last birthday) <u>10</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>MARCH 1, 1962</u> Month Day Year 9. AGE (In years last birthday) <u>10</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDUARD LAWRENCE JONES</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>ELEANOR JONES, WALDORF, MD.</u> Address _____		14. MOTHER'S MAIDEN NAME <u>ELEANOR SWANN</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CON FLA GRATION</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <u>Home Burned</u> 20c. TIME OF INJURY Month, Day, Year <u>MAR 1 1962</u> Hour <u>10:30</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Waldorf</u> (County) <u>Charles</u> (State) <u>MD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>3-1-62 - ALINTA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>3-7-62</u> 22c. NAME OF CEMETERY OR CREMATORY _____ 23. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WALDORF, MD.</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>MAR 6 '62</u> 24b. REGISTRAR'S SIGNATURE <u>C. Chas. S. Hanna</u>	

VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

08

1-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03115

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. LENGTH OF STAY IN 1b <u>7</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md, 7-Kenwood Place & T.Hts</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Raymond Keller</u>		4. DATE OF DEATH Month Day Year <u>3-24-62</u> 19 <u>62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1910</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Powder Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Dixon Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raymond Lee Keller</u>		14. MOTHER'S MAIDEN NAME <u>Anna Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>USA Yes</u>		16. SOCIAL SECURITY NO <u>213-12-1674</u>	
17. INFORMANT <u>Mary Elizabeth Mrs. Bessie Keller--(Wife)</u>		Address <u>#7 Kenwood Pl. Potomac, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4 2 6 1</u> DUE TO <u>Arterio-Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Indefinite</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-1-50</u> , 19 <u>50</u> , to <u>3-24-62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>3-24-62</u> , 19 <u>62</u> , and that death occurred at <u>3:20PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 17-Potomac Ave. Indian Head Md</u> <u>3/24/1962</u> ACTUAL SIGNATURE <u>James E. Andrews</u> PHYSICIAN'S NAME (Type) <u>James E. Andrews MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bumpy Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pomonkey, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 27 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please see the instructions on the back of this form. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 03116											
1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marbury (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 210				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MATTIE Middle LEE Last KING				4. DATE OF DEATH Month March Day 3 Year 1962							
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1940		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Charles County, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Winston Posey						14. MOTHER'S MAIDEN NAME Esther Kin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 12001		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 824X Multiple injuries extreme including DUE TO (b) Fractures of Skull, Right upper extremity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH Immediate											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased was passenger in a light pickup truck which made a left turn in the path of an oil truck coming in opposite direction, throwing out.							
20c. TIME OF INJURY Month, Day, Year March 3 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt 210		20f. (City or town) Indian Head		(County) Charles (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Frank H. G. Susan				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3/3/62			
EXAMINER'S NAME (Type) Frank A. Susan M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Indian Head, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 3/3/62		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Baptist				22d. LOCATION (City, town, or county) Marbury, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]						24a. REC'D BY REGISTRAR DATE 7 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

Transferred to Johnson & Decker

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03128

03117

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAULKNER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHARLES FAULKNER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE B. LYNCH</u>				4. DATE OF DEATH Month Day Year <u>MARCH 6, 1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 18, 1889</u>	
9. AGE (In years, last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN B. LYNCH</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN RUSSELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-32-694</u>		17. INFORMANT <u>MARGARET LYNCH FAULKNER MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular occlusion</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 years.</u> <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>59</u> to <u>March</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-4</u> 19 <u>62</u> and that death occurred at <u>7</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>F. M. JOHNSON</u>				22b. DATE SIGNED <u>3-8-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON MD.</u>				22d. ADDRESS <u>LA PLATA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-9-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>		23d. LOCATION (City, town, or county) (State) <u>BRYANTOWN, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The HUNT Funeral Home, WADERS, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03129

CERTIFICATE OF DEATH

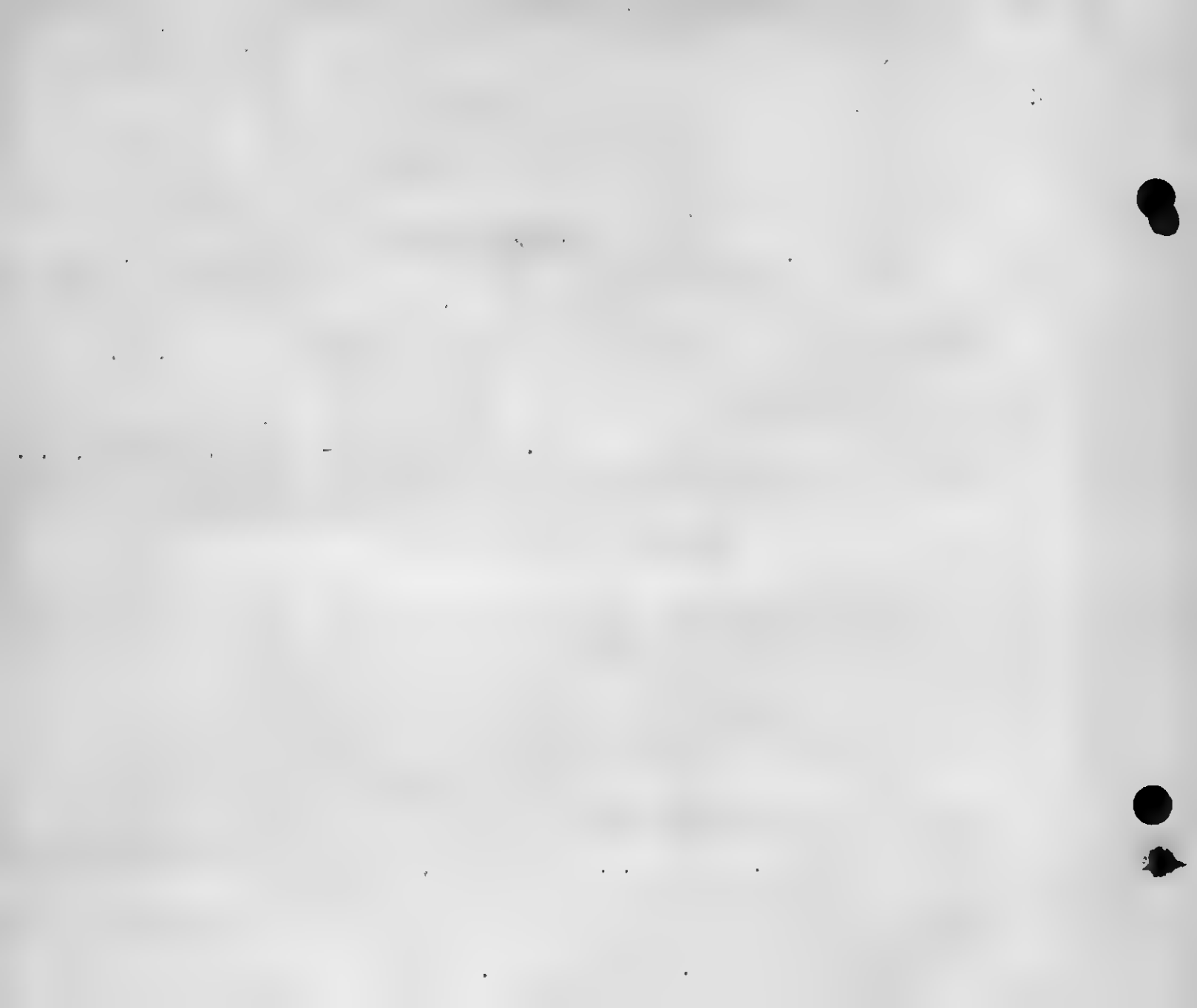
03118

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 45</u>		d. STREET ADDRESS <u>Route 45</u>	
3. NAME OF DECEASED (Type or print) <u>William Bruce Matthews</u>		4. DATE OF DEATH <u>3 4 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>December 12, 1898</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Marshal - Retired</u>		9b. AGE (In years last birthday) <u>63</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>La Plata, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Matthews</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Mr. William Bruce Matthews - Son</u>	
17. INFORMANT <u>Mr. William Bruce Matthews - Son</u>		Address <u>People Hills</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary Occlusion</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/21/1954</u> to <u>3/3/1962</u> , that (I) (we) last saw the deceased alive on <u>3/3/1962</u> , and that death occurred at <u>21.11.62</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>E. J. Edelen</u>		22b. DATE SIGNED <u>1/5/1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>		22d. ADDRESS <u>La Plata, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/5/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Rose Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>La Plata, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Irishart Funeral Home, Inc. - La Plata, Md.</u>		25a. REC'D BY REGISTRAR <u>VAR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		25c. REGISTRAR'S SIGNATURE	

TO DEPUTY AL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

MAY 10 1962									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03130									
1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN lb 1 1/2 Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicans Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY Monroe c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rochester d. STREET ADDRESS 15 Navarre Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EDWIN R. NORTHROP					4. DATE OF DEATH March 24, 1962				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH May 10, 1903				
9. AGE (In years last birthday) 58 yrs.					10. IF UNDER 1 YEAR: Months 58 Days 24 Hours 15 Min. 00				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Foreman					10b. KIND OF BUSINESS OR INDUSTRY Kodak Company				
11. BIRTHPLACE (State or foreign country) Rochester, New York					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME (Unknown) Northrup					14. MOTHER'S MAIDEN NAME Lucie Pratt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. Yes				
17. INFORMANT Mrs. Anita Northrup - Wife					Address #15 Navarre Road Rochester 21, N.Y.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 44 3X DUE TO HYPERTENSIVE ARTERIOSCLECTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (b) HEART DISEASE (a), stating the underlying cause last. (c) HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AUTO ACCIDENT, MINOR, AT TIME OF CVA 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Robert W. Merkle M.D. DATE SIGNED MAR 24, 1962									
EXAMINER'S NAME (Type) Robert W. Merkle M.D. La Plata, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/28/1962 22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery 22d. LOCATION (City, town, or country) (State) Rochester, New York									
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Md. ADDRESS Archart Funeral Home, Inc. - La Plata, Md. 24a. REC'D BY REGISTRAR MAR 27 '62 24b. REGISTRAR'S SIGNATURE Michael S. Thoma									



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
03131
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03121

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dentsville (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ON <u>Medians Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CARROLL SPALDING</u>		4. DATE OF DEATH Month Day Year <u>March 3 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 23, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ignatius Charles Spalding</u>		14. MOTHER'S MAIDEN NAME <u>Mary H. Norris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mr. Charles Spalding - Son - La Plata, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 3-3, 1954</u> to <u>3-3, 1962</u> that (I) (we) last saw the deceased alive on <u>3-3, 1962</u> , and that death occurred at <u>10:58 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>H. M. Johnson M.D.</u>		22b. DATE SIGNED <u>3-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. M. JOHNSON M.D.</u>		22d. ADDRESS <u>LA PLATA Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/3/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Church Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>La Plata, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Michael Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

03132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03122

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived * If institution Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LA PLATA, Pomfret	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEN. HOSPITAL		d. STREET ADDRESS PHYSICIANS MEN. HOSPITAL	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS EDWARD STRAK, JR.		4. DATE OF DEATH Month Day Year MARCH 21, 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1962
9. AGE (In years last birthday) yrs 10		IF UNDER 1 YEAR Months Days Hours Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) LA PLATA, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS E. STRAK, SR.		14. MOTHER'S MAIDEN NAME MARGARET WELCH.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT THOMAS STRAK, SR.		Address POMFRET, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity - 28 wks gestation 161.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 10 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia from 2 wks. bleeding of separated placenta			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at — M, from the causes and on the date stated above			
22a. SIGNATURE Robert W. Yeckle M.D.		22b. DATE SIGNED 3/21/62	
22c. PHYSICIAN'S NAME (Type) LA PLATA, MD.		22d. ADDRESS LA PLATA, MD.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/22/62	
23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S CEMETERY		23d. LOCATION (City, town, or county) (State) POMFRET, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Funeral Home, Inc.		24a. ADDRESS La Plata Md.	
25a. REC'D BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE —	
DATE MAR 27 '62			

2-001596

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18																								
03133					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03123														
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)					Reg. Dist. No.														
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
Charles		Nanjemoy			2-days		X Rural - Nanjemoy																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					None																			
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH																			
First Middle Last					Month Day Year																			
Samuel Issachar Swann					3-23-62					19														
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.												
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3-21-62		2		Months Days Hours Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?									
None					None					Maryland					USA									
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME																			
Melvin Swann					Ruby Keys																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No					None					Mother-Ruby Swann					- Nanjemoy, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Broncho</u>										2-Days														
763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) <u>Upper respiratory Infection</u>					2-Days									
DUE TO (c)																								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
None										None														
20c. TIME OF INJURY			Month, Day, Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)			(County)			(State)						
Hour a. m. p. m.			19			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																								
ACTUAL SIGNATURE										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED									
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					3-23-62									
James E. Andrews MD										Indian Head, Maryland														
22a. BURIAL CREMATION REMOVAL (Specify)			22b. DATE THEREOF			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county)			(State)												
Burial			3/24/1962			Church of Lord Jesus Christ Cemetery - Ironsides, Md.																		
23. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS					24a. REC'D BY REGISTRAR					24b. REGISTRAR'S SIGNATURE				
Arehart Funeral Home, Inc. - La Plata, Mary															MAR 27 '62					L. Plante				

2-048549

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03135

03125

1. PLACE OF DEATH a. COUNTY CHAREES MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Chares	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Indian Head		c. LENGTH OF STAY IN 1b 25 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Indian Head		d. STREET ADDRESS Rt 1. Box 65. Indian Head	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH ROLAND WELCH		4. DATE OF DEATH MARCH 2 1962	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Feb 1906
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Charles Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Lee Welch		14. MOTHER'S MAIDEN NAME Susan L. Welch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-8463	
17. INFORMANT Wife Bessie Lee Welch, Indian Head		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420 DUE TO (b) Coronary artery disease Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 min 2 1/2 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sent 1959 to March 1962, that (I) (we) last saw the deceased alive on 2 Mar 1962, and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Wooddy, M.D.		22b. DATE SIGNED 2 March 1962	
22c. PHYSICIAN'S NAME ARTHUR O. WOODDY, M.D.		22d. ADDRESS LA PLATA, MARYLAND	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-5-62	
23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		23d. LOCATION (City, town, or county) (State) WALDORF, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE The HUNT Funeral Home, WALDORF, MD.		25a. REC'D BY REG STRAR DATE 6 '02	
ADDRESS		25b. REGISTRAR'S SIGNATURE W. L. Kline	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03126

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA c. LENGTH OF STAY in b 6 Mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PHYS McH Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY CHAS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POMFRET (Rural) d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last WILLETT		4. DATE OF DEATH Month 3 Day 7 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 57 IF UNDER 1 YEAR: Months 3 Days 7 IF UNDER 24 HRS.: Hours 1 Min. 0
11. BIRTHPLACE (County & State, or foreign country) Charles County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alvin Langley		14. MOTHER'S MAIDEN NAME Margaret Crismond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. A. Clay Willett-Husband-Pomfret, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) C.A. Uterus c Metastasis 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 3-7-62 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 57 to 3-7-62 , that (I) (we) last saw the deceased alive on 3-7-62 , and that death occurred at 9AM , from the causes and on the date stated above.			
22a. SIGNATURE EJ. EDELEN		22b. DATE SIGNED 3/8/1962	
22c. PHYSICIAN'S NAME (Type) EJ. EDELEN		22d. ADDRESS Laplata Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 10, 1962	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. - La Plata, Md.		25a. REC'D BY REGISTRAR MAR 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1512

(M)

704

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03127

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Welcome c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Welcome d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Agnes Young				4. DATE OF DEATH Month Day Year 3 26 19 62																			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/20/1901		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.													
13. FATHER'S NAME Joseph Smith						14. MOTHER'S MAIDEN NAME Cassie Hawkins																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address I.P. Evans Welcome, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VASCULAR ACCIDENT 443X DUE TO HYPERTENSIVE - ARTERIOSCLEROTIC HEART DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)												INTERVAL BETWEEN ONSET AND DEATH 1 MIN.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHRONIC PULMONARY DISEASE, RES. TB														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that the (this person) attended the deceased from 9-26 , 19 61 , to MAR 26 , 19 62 that we last saw the deceased alive on FEB 15 , 19 62 , and that death occurred at 7A M, from the causes and on the date stated above.																							
22a. SIGNATURE Robert W. Merkle												ATTENDING PHYS. <input checked="" type="checkbox"/> RED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) Robert W. Merkle, M.D.												22d. ADDRESS La Plata, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 3-29-62				23c. NAME OF CEMETERY OR CREMATORY St Catherine's				23d. LOCATION (City, town or county) (State) McConchie M.D.											
24. FUNERAL DIRECTOR'S SIGNATURE Montgomery Bros 719 Remedy street												25a. REC'D BY REGISTRAR DATE 54				25b. REGISTRAR'S SIGNATURE L.B. Montgomery							

VR A15 (4)
15M 9/60

APR 2 '62

Arthur L. Finney

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VASCULAR ACCIDENT

HEART DISEASE

CHRONIC PULMONARY DISEASE

1915

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1915

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